

**[IN ACCORDANCE WITH CALIFORNIA INSURANCE CODE (CIC) SECTION 12938,  
THIS REPORT WILL BE MADE PUBLIC AND PUBLISHED ON THE  
CALIFORNIA DEPARTMENT OF INSURANCE (CDI) WEBSITE]**

**WEBSITE PUBLISHED REPORT OF THE MARKET CONDUCT  
EXAMINATION OF THE CLAIMS PRACTICES OF**

**TIME INSURANCE COMPANY  
NAIC # 69477 CDI # 1705-3**

**AS OF DECEMBER 31, 2014**

**ADOPTED MARCH 23, 2016**

**STATE OF CALIFORNIA**



**CALIFORNIA DEPARTMENT OF INSURANCE  
MARKET CONDUCT DIVISION  
FIELD CLAIMS BUREAU**

## NOTICE

**The provisions of Section 735.5(a) (b) and (c) of the California Insurance Code (CIC) describe the Commissioner's authority and exercise of discretion in the use and/or publication of any final or preliminary examination report or other associated documents. The following examination report is a report that is made public pursuant to California Insurance Code Section 12938(b)(1) which requires the publication of every adopted report on an examination of unfair or deceptive practices in the business of insurance as defined in Section 790.03 that is adopted as filed, or as modified or corrected, by the Commissioner pursuant to Section 734.1.**

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**DEPARTMENT OF INSURANCE**

Consumer Services and Market Conduct Branch  
Field Claims Bureau, 10th Floor  
300 South Spring Street  
Los Angeles, CA 90013



March 23, 2016

The Honorable Dave Jones  
Insurance Commissioner  
State of California  
300 Capitol Mall  
Sacramento, California 95814

Honorable Commissioner:

Pursuant to instructions, and under the authority granted under Part 2, Chapter 1, Article 4, Sections 730, 733, 736, and Article 6.5, Section 790.04 of the California Insurance Code; and Title 10, Chapter 5, Subchapter 7.5, Section 2695.3(a) of the California Code of Regulations, an examination was made of the claims handling practices and procedures in California of:

**Time Insurance Company  
NAIC # 69477**

**Group NAIC # 0019**

Hereinafter, the Company listed above also will be referred to as TIC or the Company.

This report is made available for public inspection and is published on the California Department of Insurance website ([www.insurance.ca.gov](http://www.insurance.ca.gov)) pursuant to California Insurance Code section 12938(b)(1).

## FOREWORD

The examination covered the claims handling practices of the aforementioned Company on Accident and Disability claims closed during the period from January 1, 2014 through December 31, 2014. The examination was made to discover, in general, if these and other operating procedures of the Company conform to the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law.

The report is written in a “report by exception” format. The report does not present a comprehensive overview of the subject insurer’s practices. The report contains a summary of pertinent information about the lines of business examined, details of the non-compliant or problematic activities that were discovered during the course of the examination and the insurer’s proposals for correcting the deficiencies. When a violation that reflects an underpayment to the claimant is discovered and the insurer corrects the underpayment, the additional amount paid is identified as a recovery in this report. While this report contains violations of law that were cited in this report by the examiners, additional violations of CIC 790.03, or other laws, not cited in this report may also apply to any or all of the non-compliant or problematic activities that are described herein.

All unacceptable or non-compliant activities may not have been discovered. Failure to identify, comment upon or criticize non-compliant practices in this state or other jurisdictions does not constitute acceptance of such practices.

Alleged violations identified in this report, any criticisms of practices and the Company’s responses, if any, have not undergone a formal administrative or judicial process.

## **SCOPE OF THE EXAMINATION**

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by the Company for use in California including any documentation maintained by the Company in support of positions or interpretations of the California Insurance Code, Fair Claims Settlement Practices Regulations, and other related statutes, regulations and case law used by the Company to ensure fair claims settlement practices.

2. A review of the application of such guidelines, procedures, and forms, by means of an examination of a sample of individual claims files and related records.

3. A review of the California Department of Insurance's (CDI) market analysis results; a review of consumer complaints and inquiries about this Company closed by the CDI during the period January 1, 2014 through December 31, 2014; and a review of previous CDI market conduct claim examination reports on this Company.

The review of the sample of individual claims files was conducted at the offices of the California Department of Insurance in Los Angeles, California.

## **EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED**

The Accident and Disability claims reviewed were closed from January 1, 2014 through December 31, 2014, referred to as the “review period”. The examiners randomly selected 290 TIC claims files for examination. The examiners cited three alleged claims handling violations of the California Insurance Code from this sample file review.

Findings of this examination included delays in claims handling.

## **RESULTS OF REVIEWS OF MARKET ANALYSIS, CONSUMER COMPLAINTS AND INQUIRIES, PREVIOUS EXAMINATIONS, AND PRIOR ENFORCEMENT ACTIONS**

The results of the market analysis review revealed that during 2014, an enforcement action was taken in the state of Oregon. The action alleged the Company's failure to timely decide on grievances or appeals. The examiners focused on this issue during the course of the file review. This issue was not reflected in the results of this examination.

The Company was the subject of 25 California consumer complaints and inquiries closed from January 1, 2014 through December 31, 2014, in regard to the line of business reviewed in this examination. The CDI alleged 17 violations of law. Of the complaints and inquiries, the CDI determined nine complaints were justified for claims handling delay, denial of claims, medical necessity, and unsatisfactory settlement offers. The examiners focused on these issues during the course of the file review.

The previous claims examination reviewed a period from March 1, 2005 through February 28, 2006. The most significant noncompliance issues identified in the previous examination report were the Company's failure upon denying a claim to provide written notice to the provider that it may seek review by the Department; the Company's failure to respond to communications within 15 calendar days; and the Company's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application before issuing the policy or certificate. These issues were not identified as problematic in the current examination.

The Company has not been the subject of any formal California enforcement actions.

## DETAILS OF THE CURRENT EXAMINATION

Further details with respect to the examination and alleged violations are provided in the following tables and summaries:

<b>TIC SAMPLE FILES REVIEW</b>			
<b>LINE OF BUSINESS / CATEGORY</b>	<b>CLAIMS IN REVIEW PERIOD</b>	<b>SAMPLE FILES REVIEWED</b>	<b>NUMBER OF ALLEGED VIOLATIONS</b>
Accident and Disability / Individual Major Medical	281,554	68	1
Accident and Disability / Short Term Medical	3,376	67	0
Accident and Disability / Dental Supplement	15,054	68	0
Accident and Disability / Accident Supplement	94	23	2
Accident and Disability / Appeals	1,002	64	0
<b>TOTALS</b>	301,080	290	3

## TABLE OF TOTAL ALLEGED VIOLATIONS

Citation	Description of Allegation	TIC Number of Alleged Violations
CIC §10123.13(a) *[CIC §790.03(h)(5)]	The Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim.	1
CCR §2695.7(b) *[CIC §790.03(h)(4)]	The Company failed, upon receiving proof of claim, to accept or deny the claim within 40 calendar days.	1
CCR §2695.7(c)(1) *[CIC §790.03(h)(3)]	The Company failed to provide written notice of the need for additional time or information every 30 calendar days.	1
<b>Total Number of Alleged Violations</b>		<b>3</b>

### \*DESCRIPTONS OF APPLICABLE UNFAIR CLAIMS SETTLEMENT PRACTICES

- |                   |  |
|-------------------|--|
| CIC §790.03(h)(3) | The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.             |
| CIC §790.03(h)(4) | The Company failed to affirm or deny coverage of claims within a reasonable time after proof of loss requirements had been completed and submitted by the insured. |
| CIC §790.03(h)(5) | The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.                                  |

**TABLE OF ALLEGED VIOLATIONS BY LINE OF BUSINESS**

<b>ACCIDENT AND DISABILITY</b> 2014 Written Premium: \$131,878,968  <b>AMOUNT OF RECOVERIES            \$100.00</b>	<b>NUMBER OF ALLEGED VIOLATIONS</b>
CIC §10123.13(a) [CIC §790.03(h)(5)]	1
CCR §2695.7(b) [CIC §790.03(h)(4)]	1
CCR §2695.7(c)(1) [CIC §790.03(h)(3)]	1
<b>SUBTOTAL</b>	<b>3</b>
<b>TOTAL</b>	<b>3</b>

## SUMMARY OF EXAMINATION RESULTS

The following is a brief summary of the criticisms that were developed during the course of this examination related to the violations alleged in this report.

In response to each criticism, the Company is required to identify remedial or corrective action that has been or will be taken to correct the deficiency. The Company is obligated to ensure that compliance is achieved.

Any noncompliant practices identified in this report may extend to other jurisdictions. The Company was asked if it intends to take appropriate corrective action in all jurisdictions where applicable. The Company intends to implement corrective actions in all jurisdictions.

Money recovered within the scope of this report was \$100.00 as described in section number two below. As a result of the examination, the total amount of money returned to claimants within the scope of this report was \$100.00.

### **ACCIDENT AND DISABILITY**

1. **In one instance, the Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim.** In this instance the Company settled the claim beyond the statutory timeline and failed to include the applicable interest with its payment. The Department alleges this act is in violation of CIC §10123.13(a) and is an unfair practice under CIC §790.03(h)(5).

**Summary of the Company's Response:** The Company acknowledges that more than 30 working days elapsed to process this claim. The Company states its standard procedure is to timely issue payments and interest when appropriate. However, a system issue occurred that impacted payment of interest on certain claims. The Company identified and corrected the system issue in November 2014 and reports the appropriate interest payments on all impacted claims including this specific claim was issued prior to the onset of the Department's examination. The Company provided this examination finding for feedback to its Implementation Team on October 8, 2015. The Company determined that no additional corrective action is needed as its payment of interest project to comply with the requirements of CIC §10123.13 were completed in

December 2014. The Company also reinforced its California Prompt Pay Requirements on its internal website on November 2, 2015.

**2. In one instance, the Company failed, upon receiving proof of claim, to accept or deny the claim within 40 calendar days.** In this instance, the Company received sufficient proof of claim; however the claim on the supplement accident policy was closed in error without payment. The Department alleges this act is in violation of CCR §2695.7(b) and is an unfair practice under CIC §790.03(h)(4).

**Summary of the Company's Response:** The Company acknowledges this instance involved a claim received on January 21, 2014 under an Accident Indemnity policy. As a result of the examination, the Company reopened the claim and determined that additional benefits was payable for the Accident Emergency Treatment benefit. On August 25, 2015, the Company issued the amount of \$100.00 to the claimant. On October 8, 2015, a comprehensive review of the requirements of CCR §2695.7(b) was provided to the Company's Implementation Team. These requirements were also published as a Compliance Bulletin on the Company's intranet on October 30, 2015 for reinforcement.

**3. In one instance, the Company failed to provide written notice of the need for additional time or information every 30 calendar days.** In this instance, the request for additional information was sent on the 42<sup>nd</sup> calendar day. The Department alleges this act is in violation of CCR §2695.7(c)(1) and is an unfair practice under CIC §790.03(h)(3).

**Summary of the Company's Response:** This instance involved a claim received on August 6, 2014. The Company requested additional information needed to adjudicate the claim 42 calendar days from receipt of claim, and beyond regulatory timelines. On October 8, 2015, a comprehensive review of the requirements of CCR §2695.7(c)(1) was provided to the Company's Implementation Team. These requirements were also published as a Compliance Bulletin on the Company's intranet on October 30, 2015 for reinforcement.

